**University Hospital McDuffie**
Indigent/Charity Care Program
2460 Washington Rd.
Thomson, GA 30824

# Verification Checklist

Applicant's Name

CUSTOMER SERVICE CENTER

Applicant's Address

(706) 828-2333

City, State, Zip

Account Number

Phone Number

Date Given/Mailed

**YOU MUST PROVIDE THE VERIFICATION REQUESTED BELOW NO LATER THAN:_____**

[ ] Birth certificates or other acceptable proof of citizenship

[ ] Copy of drivers license or ID and SS card.

[ ] Work history report from the GA Dept. of Labor at 674 Washington Rd. (One Stop) building

[ ] Check stubs or statement from employer for past 3 months

[ ] Letter of award for social security, veteran's benefits, workmen's compensation or any other government benefits

[ ] Proof of child support , alimony,unemployment compensation or any other unearned income

[ ] Checking and/or Savings account statements for the past 3 months

[ ] Statement from person you live with concerning living arrangements and contributions made to the household (if any)

[ ] Statement from person who is helping you with your bills

[ ] Taxes from previous year

[ ] 3 **notarized** statements from friends stating how long they know you have been separated &mail in husband/wife name

[ ] Divorce decree

[ ] Proof job does not offer health insurance

[ ] Completed Application

**By signing below, I understand that if I do not provide the checked items by the date listed on this form, my application will be denied and I will have to wait 90 days until I am allowed to apply for University Hospital McDuffie's Indigent/Charity Care Program for any services I incur in the future.**

X_____ _____

Applicant's Signature Date:

# University Hospital McDuffie
# Indigent/Charity Care Program

DOA _____
DOE _____

We will consider this application without regard to race, color, sex, age, handicap, religion, national origin, or political belief.

**Name (Please Print):**

| First | M.I. | Last | Date of Birth | Social Security # | Date |
|---|---|---|---|---|---|
| | | | | | |

**Patient's Name:**

| First | M.I. | Last | Telephone Number |
|---|---|---|---|
| | | | |

**Mailing Address** City State Zip

Residence, if different from Mailing Address City State Zip

Please list everyone in the household including yourself

| First Name | M.I. | Last Name | Sr., Jr., III, etc. | SEX M / F | Date of Birth | Relationship | Social Security # |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
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1. List any name, including maiden name, that you have used or have been known by:

First Name(s) M.I. Last Name(s)

2. Are you currently receiving or previously received TANF?(Temporary Assistance for Needy Families
   No _____ Yes _____ If Yes, when and where? _____

3. Are you currently receiving or previously received FS?(Food Stamps)
   No _____ Yes _____ If Yes, when and where? _____

4. Are you currently receiving or previously received Medicaid?
   No _____ Yes _____ If Yes, when and where? _____

5. Have you lived in McDuffie County for at least six consecutive months?
   No _____ Yes _____ If Yes, when and where? _____

6. Has anyone listed on this form married or divorced in the last six (6) months?
   No _____ Yes _____ If Yes, when and where? _____

7. Is anyone covered by a Health Policy other than Medicaid? No _____ Yes _____

| Name of those Covered | Name of Insurance | Policy Number |
|---|---|---|
| | | |
| | | |
| | | |

8. List anyone in your household who is pregnant: _____

9. Do you expect a change in any of the information on this form?
   No _____ Yes _____ If Yes, what and when? _____

University Hospital McDuffie
Indigent/ Charity Care Program

**Income Resource Statement**

I, _____, do swear or affirm, for purposes of determining eligibility for the receipt of UHM Indigent/ Charity Care that I, ( ) spouse, ( ) children or ( ) responsible household member, for whom I have applied for assistance, do/does not have income/resources other than that which I have described below.

| Earned Income | YES | NO | Verification of Documentation | Amount | Frequency |
|---|---|---|---|---|---|
| | | | | | |
| Other/Not Listed | | | | | |
| Wages/Salaries | | | | | |
| Self Employment | | | | | |
| Roomer/Boarders | | | | | |
| Job Corps | | | | | |
| JTPA | | | | | |
| Social Security | | | | | |
| TANF | | | | | |
| RSDI | | | | | |
| SSI | | | | | |
| Alimony Received | | | | | |
| Child Support Received | | | | | |
| Contributions | | | | | |
| Veteran's Benefits | | | | | |
| Military Allotments | | | | | |
| Workman's Compensation | | | | | |
| Unemployment Compensation | | | | | |
| Railroad Retirement | | | | | |
| Pension Fund Pension Benefits | | | | | |
| Lump Sums | | | | | |
| Employee's Retirement | | | | | |
| Rent from Apart. /House /Bldg. | | | | | |
| Interest/ Dividends | | | | | |
| Benefits | | | | | |
| | | | | | |

# University Hospital McDuffie
# Indigent/Charity Care Program

## Expense Statement

**Please fill out both pages of this form** before you see your caseworker. This information is necessary to determine your eligibility for assistance.

Name_____

If you are applying for assistance or having your eligibility re-determined:

Explain why you need assistance:

_____

_____

_____

_____

How have you been paying your bills?

_____

_____

_____

_____

What income does your household have?

_____

_____

_____

_____

Who do you live with? _____Self_____Spouse_____Children_____Family_____Friends_____Other

Have you been to any other hospital in the last year? _____Yes _____No

Do you receive workers comp, VA or military benefits? _____Yes _____No

Have you had any accidents (car/work-related) recently? _____Yes _____No

Do you have any pending lawsuits? _____Yes _____No

Have you received any type of lump sum recently? _____Yes _____No

If working, does your job offer health insurance? _____Yes _____No _____N/A

Have you ever been approved for indigent care at **ANOTHER** hospital or facility? _____Yes _____No

I certify that the information given is true and correct to the best of my knowledge and belief and if I willingly give false information I will lose my opportunity to participate in the University Hospital Indigent/Charity Care Program.

_____ _____

Signature (Applicant/Recipient) Date

I have reviewed the information on this form with the applicant/recipient.

_____ _____

Signature (Eligibility Worker) Date